NOTICE OF INDEPENDENT REVIEW DECISION

Date: February 3, 2003

RE: MDR Tracking #: M2-03-0431-01-ss
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

___ is a 39 yo male who injured his low back at work on ___ while trying to move a toilet. He received treatment post injury by ___ an orthopaedic Surgeon and returned to full duty on 12/08/00. He continued to have problems and was seen by another Orthopaedic Surgeon, ___. He was eventually referred for Neurosurgical consultation to ___. He received one epidural steroid injection and had an MRI that was interpreted as demonstrating a central disc herniation at L5 abutting the S1 nerve roots especially on the right side. A subsequent lumbar myelogram and Computerized Tomography with contrast on 4/12/01 indicated no evidence of nerve root compromise. His complaints involved the left lower extremity and left low back and sacroiliac region. More low back than extremity pain. Subsequently ___ recommended lumbar arthrodesis with pedicle screws. He was referred for psychological evaluation and had an abnormal MMPI indicating poor stress tolerance.

Requested Service(s)

Lumbar arthrodesis using pedicle screws

Decision

I agree with the insurance carrier that the above procedure is not medically necessary.

Rationale/Basis for Decision

There are no physical findings that are consistent with the need for surgery. His complaints are on the left the findings on imaging studies are principally on the right and they are not conclusive. He has no demonstrable objective neurological findings that clinically correlate with the imaging studies, and has no sensory or motor deficits that were objectively demonstrated. His MMPI findings are predictive of a poor surgical outcome and this test has a high correlation when abnormal, with poor surgical results. There are no flexion/extension lumbar radiographic studies that indicate segmental instability which is one of the prime indicators for arthrodesis. I see no findings in any of the records I reviewed, including ___ records, that indicate any need for surgery.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (pre-authorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).
Sincerely,

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requester and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 3rd day of February 2003.